STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING CENTER	2200 WHITE RIVER BOULEVARD MUNCIE, IN47303

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 22, 23, 24, 25, and 26, 2011 Facility number: 000013 Provider number: 155038 AIM number: 100266100 Survey team: Betty Retherford, RN-TC Delinda Easterly, RN Ginger McNamee, RN Karen Lewis, RN Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 10 Medicaid: 60 Other: 3 Total: 73 Stage 2 Sample: 35 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on August	F0000	F000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Parkview Nursing Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective 9-26-2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	31, 2011 by Bev Faulkner, RN			
F0242 SS=D	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure residents received fresh ice water in their rooms each shift as they desired for 3 of 19 residents interviewed related to ice water in a Stage 2 sample of 34. (Resident #'s 88, 76 and 40) Findings include: 1.) The clinical record for Resident #88 was reviewed on 8/24/11 at 2:30 p.m. Resident #88's current diagnoses included, but were not limited to, Parkinson's, alcohol abuse, seizure disorder, hypertension, anxiety and depression. Resident #88 was identified as interviewable on a list, which was	F0242	Resident #88, 76 and 40 and the Resident Council will be interviewed to determine if they need ice water passed more frequently than once every shift and will be provided ice water as indicated per their choice and frequency. Staff were in serviced on 9/8/2011 to ensure the provision of ice water is passed every shift and as per resident requests. Residents will be interviewed daily for compliance of ice water being passed each shift and the Resident Council will be asked at its regular monthly meeting and if special meetings are held if ice water pass is being provided each shift and as requested or desired if more frequent offer of ice water is needed. Any concerns that the Resident Council addresses will be written on a Resident Concern Form and provided to the Administrator and	09/26/2011

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	provided by the Administrator on 8/22/11 at 12 noon. During an interview with Resident #88 on 8/22/11 at 12:06 p.m., he indicated he did not receive fresh ice water passed in his room on a daily basis. He indicated he had to ask for ice water if he wanted it. 2.) During an interview with Resident #40, the Resident Council President, on 8/25/11 at 1:00 p.m., he indicated he did not receive fresh ice water in his room on a daily basis. He indicated he had to ask for ice water if he wanted it. He indicated he knew the CNAs were to pass ice water three times a day but they did not. He further indicated the water in his room had been sitting there for a few days. 3.) During an interview with Resident #76 on 8/24/11 at 10:00 a.m., she indicated she did not get ice water 3 times a day. She indicated she had to ask for water if she wanted it. She also indicated sometimes she would have to go get the water herself. Resident #76 was on an interviewable list provided by the Administrator on 8/22/11 at 12 noon. 4.) Review of the monthly resident council minutes indicated on the		remedy, action or resolution will be addressed and the next regularly scheduled Resident Council meeting. This will be monitored by the administrator or designee. Any recommendations will be reviewed by the QA Committee to ensure any concerns from the Resident Council are addressed to include the procedure of passing ice water at its regularly scheduled monthly meeting or as needed for compliance. Unit managers will complete rounds to ensure Ice water has been provided every shift daily times two weeks, three times a week for four weeks, then one time a week for two months and monthly thereafter. DON/or designee will complete rounds weekly For three months to ensure ice water has been Provided every shift. Identified trends will be reviewed in QAA monthly For 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and	

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	following dates residents complained about not receiving ice water passed in their room, 1/7/11, residents complained about nursing not bringing ice water, indicated they have to ask for water. 4/19/11, residents indicated they have to ask for ice water, staff do not pass to rooms daily Review of the current facility policy, dated April 2010, titled "Hydration Status", provided by the RN Consultant on 8/26/11 at 1:30 p.m. indicated the following, " Extendicare Health Services, In. (EHSI) strives to reduce the risk of fluid imbalance by identifying risk, managing, stabilizing, and reversing dehydration and promoting resident care practices to improve hydration... 7. Implement individualized interventions based on resident needs and goals, considering the resident's and/or legal guardian's choice and preferences which promote fluid intake to maintain sufficient hydration for the resident which may include, but are not limited to the following, a. Assure a container of water is		including termination. Any identified trends will be forwarded to the administrator for review and presented to QAA to determine further educational needs. Completion Date of 9-26-2011.	

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	within the resident's reach at all times, unless contraindicated.... c. Provide fluid in an amount that can be managed by the resident independently"... During an interview with the Director of Nursing on 8/26/11 at 1:45 p.m., she indicated the CNAs were expected to pass ice water in the resident's rooms on every shift. 3.1-3(u)(1)			
F0244 SS=E	When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to ensure resident council grievances were acted upon in a timely manner to prevent continued concerns for 5 of 19 residents reviewed for food quality and availability of ice water in a Stage 2 Sample of 35. (Resident #'s 76, 10, 40, 88, and 48) Findings include: 1.) Review of the resident council minutes from January 2011 through	F0244	Residents #76, 10, 40, 88 and 48 had voiced a concern at the Resident Council about cold food. These residents will be interviewed to determine their choice of the food temperatures and also the passing of ice water and to determine their need for improvement on the food temperatures and passing ice water. Staff was in-serviced on 9/8/2011 to ensure the provision of proper food temperatures and ice water is passed every shift and as per resident requests. Residents will be interviewed daily	09/26/2011

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	August 2011, the following food related concerns were noted: January 7, 2011: "Food usually cold." "Not bringing ice water, have to ask for it." February 3, 2011: "Breakfast on hall still cold." "Dinner is cold, and weekends (food) is cold." The minutes of the meeting lacked any information and/or response related to the January complaint of cold food. The minutes lacked any response to the complaints of ice water not being passed, but did indicate it was being passed at that time. March 4, 2011: "No discussion of old minutes." The March minutes lacked any information and/or response related to the February complaints of cold food. April 19, 2011: "No discussion of old minutes." "Meals not always hot." "Only ice, no water. Keep telling them they don't listen." A Resident Council Report, dated 4/20/11, and signed by the Administrator on 4/29/11, indicated the dietary department had been provided training on food preferences and food temperatures. The report lacked any information related to ice water concerns.		for compliance of food temperatures and ice water being passed each shift. Resident Council will be asked at its regular monthly meeting if food temperatures and ice water pass is being provided each shift and as requested or desired. Any concerns that the Resident Council addresses will be written on a Resident Concern Form and provided to the Administrator. Remedy, action or resolution will be addressed at the next regularly scheduled Resident Council meeting. This will be monitored by the administrator or designee. Any recommendations will be reviewed by the QA Committee to ensure any concerns from the Resident Council are addressed to include the procedure of passing ice water at its regularly scheduled monthly meeting or as needed for compliance. Unit managers will complete rounds to ensure Ice water has been provided every shift daily times two weeks, three times a week for four weeks, then one time a week for two months and monthly thereafter. DON/or designee will complete rounds weekly For three months to ensure	

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	June 20, 2011: "Food is okay, but always cold." No minutes were provided for a July meeting. The meeting on 8/11/11 lacked any information related to a response to the 6/4/11 meeting. 2.) During an interview with Resident #40, the Resident Council President, (identified as "interviewable" by the facility) on 8/25/11 at 1:00 p.m., he indicated residents have told him the food is sometimes cold. He indicated they were supposed to get ice water three times a day but he frequently has to get ice water himself. He indicated the water in his room had been sitting there for a day or so. He indicated the facility did not always respond to their grievances. " I don't know if they forget or what." He indicated sometimes the problems still occur and there continues to be concerns related to cold food and ice water. 3.) The clinical record for Resident #10 was reviewed on 8/24/11 at 2:30 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 6/10/11, indicated Resident #10 had no problems with		ice water has been Provided every shift. Dietary manager will monitor temperature and Palatable of hall and dining room trays daily times two weeks, then three times a week for four weeks and then weekly. Adminitrator will follow up with dietary temperature logs weekly to ensure proper temperatures are being observed. Identified trends will be reviewed in QAA monthly For 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QAA to determine further educational needs. Completion Date of 9-26-2011.	

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	his ability to understand others. During an interview with Resident #10 on 8/23/11 at 9:20 a.m., information was requested regarding facility meals and food service. Resident #10 indicated he ate his meals in his room. He indicated there were still problems with cold food and the food was not always hot. 4.) The clinical record for Resident #76 was reviewed on 8/24/11 at 10 a.m. Resident #76 was identified as interviewable on the facility "Interviewable" list. During an interview on 8/23/11 at 12:55 p.m., Resident #76 indicated there continued to be problems with the food being cold. She indicated she eats her meals in her room. She indicated the food was cold at times, "almost every day." She also indicated ice water was not always passed as it was supposed to be and she frequently had to go get it herself. 5.) During an interview on, 8/23/11 at 12:50 p.m., Resident #48 (identified as interviewable on the Interviewable list), indicated he ate meals in his room. He indicated the food was often cold by the time he got it.			

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	6.) During an interview on 8/22/11 at 12:05 p.m., Resident #88 (identified as interviewable on the Interviewable list), indicated they did not always get ice water. He indicated "You have to ask for it." 7.) During an interview with the Administrator on 8/25/11 at 12:25 p.m., additional information was requested related to facility responses to the concerns made in the resident council meetings noted above. The only response provided by the Administrator related to cold food and ice water issues was the one dated 4/20/11 and noted above. During an interview on 8/26/11 at 10:50 a.m., the Administrator indicated there were lots of changes in the facility staff around November of 2010 and some of the facility protocols had not been followed. He indicated he had no other information to provide related to the facility's response to the resident council concerns noted above. 3.1-3(l)			

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F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observations, record review, and interviews, the facility failed to ensure the activity program met resident activity needs for 1 of 3 residents reviewed for activities in a Stage 2 Sample of 35 (Resident #44). Findings include: The clinical record for Resident #44 was reviewed on 8/24/11 at 9:45 a.m. Current diagnoses for Resident #44 included, but were not limited to, major depression, dementia, right hemiplegia secondary to brain injury. During observation on the following dates and time Resident #44 was observed up in her wheelchair in her room without any type of activity occurring, 8/22/11, at 10:30 a.m., 1:45 p.m. and 3:20 p.m. 8/23/11, at 9:00 a.m., 11:00 a.m. and 4:00 p.m. An admission Minimum Data Set Assessment, dated 1/1/11 indicated	F0248	Resident #44's care plan was reviewed and the care plan for this resident was updated to include activity preferences and level of participation. Resident #44's Activity Progress notes were updated to include a summary of her activity preferences and participation level. An Activity Assessment was completed and the results were then care planned. All resident Activity Care Plans were reviewed to ensure the Activity Assessments provided the residents needs and the care plan reflected these needs. Any care plans that were determined to need updated to reflect their assessment was completed. Residents will be reviewed by the IDT team weekdays at DCR, at time of initial/annual assessment and quarterly assessment for needed updates to ensure systemic changes are effective and any changes of resident conditions are addressed in the care plan to reflect activity needs. This will be monitored by the administrator or designee. Any recommendations will be reviewed by the QA committee monthly to ensure changes to the activity programming to meet	09/26/2011

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	during a resident interview the resident indicated the following activities were important to her, listening to music, doing things with a group of people, doing her favorite activities, going outside when the weather is good and participating in religious practices. A Quarterly Minimum Data Set Assessment, dated 7/20/11 indicated Resident #44 required extensive assistance from the staff with all activities of daily living. Review of a healthcare plan, dated 8/21/11, indicated the resident did not have any limitations related to activities. The goal for the activity pursuit patterns plan of care was, will participate independently and with assistance, will participate in activities of choice 7 times per week, will participate in group activities listed as bingo and exercise, interventions included, offer activities as preferred cards -UNO, exercise, country music, Christian spiritual activities, wheeling outdoors, smoking, watching TV, talking with peers and family, outings, were listed as interests, provide monthly calendar for resident, provide assistance with transportation and provide in room supplies for leisure.		assessed care plan needs of the residents. Activity Director will conduct documented audit of Residents activity needs weekly times 4 weeks and then as appropriate using the MDS schedule thereafter. Audits will be submitted monthly for 3 months and quarterly thereafter at the center QA meetings. Identified trends will be addressed as deemed appropriate by the QA Committee through 1:1 re-education and the appropriate disciplinary process per policy. Completion Date of 9-26-2011.	

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	The most current activity progress note on the clinical record was dated 2/11/11. The note indicated, the resident had attended 7 activity programs on average on a weekly basis, assessment reviewed and remains appropriate to needs, attendance / participation summary - resident structured leisure activities include smoking , resident independent activities in room include, watching TV and reading books, resident's life routine includes, going to smoke and watching TV, progress toward activity goals, not met. During an interview with the Director of Nursing on 8/24/11 at 10:30 a.m., she was asked the name of the facility activity director. She indicated the facility did not currently have an activity director on staff. Requested activity attendance records for Resident #44 for June, July, and August. Review of the activity record provided by the Director of Nursing on 8/24/11 at 2:30 p.m., indicated the following, June 2011 activity attendance record indicated Resident #44 attended 5 activities for the entire month.			

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	July 2011 activity record indicated the resident attended 7 activities for the month. The August 2011 activity record through 8/23/11 indicated the resident had attended 5 activities. The resident was not listed as having attended any activities on 8/22/11 and 8/23/11. During an interview with the Administrator on 8/24/11 at 12:30 p.m., he indicated the previous Activity Directors last day in the facility was 7/13/11. During an interview with the Administrator on 8/26/11 at 3:45 p.m., he indicated the facility had no additional information to provide related to Resident #44 having participated in any activities other than the times listed above. 3.1-33(a)			
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure resident	F0253	The East Side Shower Room and Rooms 205, 206, 210, 216, 220,	09/26/2011

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	rooms and shower rooms were properly maintained and in good repair for 8 of 34 resident rooms observed (Room numbers 205, 206, 210, 216, 220, 308, 310, and 114), and 1 of 2 shower rooms currently in use by residents residing on the East Hall (East Hall shower). This affected 15 residents who resided in 8 of 34 rooms observed and potentially affected 73 residents who used the East Hall shower. Findings include: During the environmental tour with the Maintenance Director and the Administrator on 8/26/11 at 9:30 a.m., the following concerns were identified, a. The bathroom floor in Room 205 had 2 discolored areas of substance approximately 4 inches by 4 inches in diameter that were black, dark brown in color. At the time of the observation the Administrator wet a paper towel and the substances on the bathroom floor were removed. b. The metal door frame to the bathroom in Room 210 was gouged and paint was missing. c. The bathroom in Room 220 had sections of caulk missing from around		308, 310 and 114 were placed on maintenance work orders and the repairs for each room were completed. Room 205 the bathroom floor was cleaned by housekeeping to remove the black spots, Room 210 the metal door frame to the bathroom gouge was repaired and the door frame painted. Room 220 the caulk missing around the stool was repaired and flooring repaired. Room 308 the caulking around the stool was repaired and the water leak stopped from the stool. Room 206 the caulking around the stool was repaired. Room 310 the dent in the door was repaired. The closet doors in rooms 216, 114, 220, 210 and 210 were placed back on the tracks and the floor tracking for the closet doors was put in place. The East Hall shower room cracked and broken ceramic tile flooring was repaired and the cove base has been replaced. All resident bathrooms and rooms have been inspected for needed repairs and those repairs have been scheduled for completion. Staff were in serviced on 9-8-2011 to ensure the completion of work orders when there are maintenance or broken items that need repair are properly reported so they can be scheduled for repair. Rounds for repairs will be completed by the Administrator with the maintenance director weekly to ensure the resident	

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	the stool, the caulk that was in place was discolored and brown in color. d .The bathroom in Room 308 had sections of caulk missing from around the stool. Water was observed on the floor next to the stool. e. The bathroom in Room 206 had caulk around the stool that was brown and discolored. f. The bathroom door in Room 310 had a dent in the wooden door approximately the size of a baseball. g. The closet doors in Resident Rooms 216, 114, 220, 310 and 210 were off the tracks and were nonfunctional. h. The East Hall shower had a section of cove base approximately 2 feet in length missing from the floor and the wallboard was exposed. The shower room had 5 sections of ceramic tiles missing from the floor. During an interview with the Maintenance Director at the time of the environmental tour, he indicated the above concerns needed to be repaired. 3.1-19(f)		rooms are in good repair. Any recommendations will be made to the QA committee at its regularly scheduled meeting monthly to ensure resident care areas are in good repair. Maintenance supervisor will complete rounds daily times two weeks, then three times a week for four weeks and then weekly thereafter to ensure resident rooms and shower rooms are properly maintained and in good repair. Adminitrator will complete room checks weekly for threes months. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA to determine further educational	

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			needs. Completion Date 9-26-2011.	
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, observation, and interview, the facility failed to ensure a comprehensive health care plan was developed for 3 of 28 residents reviewed for comprehensive health care plan development in a Stage 2 sample of 35. (Resident #'s 1, 10, and 49.) Findings include: 1.) The clinical record for Resident #49 was reviewed on 8/24/11 at 2:45 p.m.	F0279	The care plans for residents #1, 10 and 49 were updated. Resident #49 care plan was updated to include refusal of care and treatment, Resident #10 care plan was updated to include seizure disorder and Resident #1 care plan was updated to include post cataract removal and treatments and medications for this condition. All care plans were reviewed and updated as necessary. IDT will review all new orders and diagnosis and include on the residents care plan. This process will be completed from the 24 hour report and reviewed in the	09/26/2011

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	Diagnoses for Resident #49 included, but were not limited to, pressure ulcers, diabetes mellitus, hypertension, and congestive heart failure. The nursing notes indicated the resident refused treatment including, but not limited to, going to wound center appointments, turning/repositioning, and foot wound care, 11 times in the time frame of 6/22/11 to 8/20/11. The clinical record lacked any comprehensive health care plan (HCP) having been developed related to Resident #49 refusing care. During an interview with the Director of Nursing (DoN) on 8/25/11 at 12:25 p.m., additional information was requested related to the lack of any comprehensive HCP having been developed regarding the resident's refusal of care/treatment. During an interview with the Director of Social Services (DSS) on 8/25/11 at 2:20 p.m., she indicated the Mood and Behavior Symptom Assessment/Plan of Care, dated 7/27/11, included, but was not limited to:		daily clinical review and proceed to care plan. This will be monitored by the DON or designee and reviewed by QA committee will review at least monthly residents with new diagnosis and medication changes to ensure they are included on the residents plan of care. DON/or designee will care plans for any needed updates daily clinical review. Unit Managers will review care plans for necessary updates with all new orders daily times two weeks, then three times a week for four weeks and then weekly for two months and then monthly. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented	

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	Assessment: Expresses desire to die and states she will accomplish this by no longer eating or going to doctor appointments Goal: Resident to intake appropriate nutrition and seek advise of medical professionals. Interventions: Family notified and to speak with resident. Food to be offered and possible consult regarding G-tube. Set doctor appointments. Psych consult (in house) to be scheduled. 15 minute checks for 72 hours due to suicidal ideations. The resident's mood and behavior symptom care plan had no additional measurable goals and interventions to address the resident's refusal of care/treatment. The care plan had no additional updated interventions to reflect the resident's possible G-tube consult, psych consult, and 15 minute checks due to suicidal ideations. The facility failed to provide any additional information as of exit on 8/26/11. 2.) The clinical record for Resident #10 was reviewed on 8/24/11 at 2:30 p.m.		and reviewed during QAA tio detiermine furtiher educational needs. Completion Date 9-26-2011	

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	Diagnosis for Resident #10 included, but were not limited to, acute hypoxic respiratory failure secondary to cerebral vascular accident, seizure disorder, and renal insufficiency. The clinical record indicated Resident #10 received phenytoin sodium (an anticonvulsant medication) 300 milligrams, twice daily related to his diagnosis of a seizure disorder. Seizure disorder was listed on the fall prevention health care plan as an added fall risk, but it did not identify the need for medications to prevent seizures and/or any possible monitoring needed related to the diagnosis and medication use. The clinical record lacked any comprehensive health care plan having been developed related to his diagnosis of a seizure disorder requiring the need for an anticonvulsant medication and possible monitoring. During an interview with the Administrator and Director of nursing on 8/25/11 at 12:15 p.m., additional information was requested related to the lack of an comprehensive health care plan having been developed for Resident #10's diagnosis of a seizure			

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	disorder. The facility failed to provide any additional information as of exit on 8/26/11. 3.) The clinical record for Resident #1 was reviewed on 8/24/11 at 10:30 a.m. Diagnosis for Resident #1 included, but was not limited to, status post cataract removal. During observation on 8/22/11 at 10:00 a.m., LPN #4 administered an eye drop medication to Resident #1. The eye drop administered was Prednisolone AC (an anti-inflammatory eye drop) 1% eye drops one drop to the left eye. The resident's left eye was noted to be partially closed. The clinical record lacked any comprehensive health care plan having been developed related to the resident having had cataract surgery and the need for eye drops to be given. During an interview on 8/26/11 at 2:30 p.m., the Consultant RN indicated she was unable to provide any comprehensive health care plan			

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	related to the resident having had cataract surgery and the need for eye drops four times daily. 4.) Review of the current facility policy, dated 1/08, titled "Plan of Care," provided by the DoN on 8/26/11, at 1:30 p.m., included, but was not limited to, the following: "POLICY A Plan of Care is part of the documentation process.... ...PROCEDURE... ...2. Complete the Plan of Care by including the following:... ...c. Identified need d. Realistic, measurable resident goal e. Projected date the goal will be met f. Specific individualized interventions in the "Intervention" column... ...h. Signature and date..." 5.) Review of the current facility			

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	policy, dated 2/11, titled "Resident/Family Conference," provided by the DoN on 8/26/11, at 1:30 p.m., included, but was not limited to, the following: "Procedure... ...7. Seek options with the help of the attending physician, resident or legal representative if the resident or legal representative refuse a prescribed treatment. 8. Assist nursing and other clinicians with efforts to identify other goals and find alternative methods of addressing the problem(s) if the resident or legal representative refuse a prescribed treatment...." 3.1-35(a)			

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on record review, and interview, the facility failed to ensure health care plans were reviewed and updated for 1 of 28 residents in a Stage 2 sample of 35. (Resident #45). Findings include: 1.) Resident #45's clinical record review was completed on 8/25/11 at 9:03 a.m. The resident's health care plan for activities was a short stay plan of care initiated 3/15/11. The target dates for the care plan	F0280	Resident #48 care plan was updated immediately. All care plans were audited to determine the need for any updates. All care plans will be audited monthly to ensure the care plans are up to date by the Interdisciplinary Team. This will be monitored by the DON or designee and reviewed by the QA committee monthly for any discrepancies in the plan of care and updates. DON/or designee will care plans for any neede updates daily clinical review. Unit Managers will review care plans for necessary updates	09/26/2011

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	problem goals were dated 6/11. During an interview with the Director of Nursing and Administrator on 8/25/11 at 12:25 p.m., additional information was requested related to the lack of current health care plan reviews for Resident #45. During an interview with the Director of Nursing on 8/25/11 at 2:30 p.m., she indicated the health care plan for Resident #45 had not been updated until 8/25/11. 2.) Review of the current facility policy, dated 1/08, titled "Plan of Care," provided by the DoN on 8/26/11, at 1:30 p.m., included, but was not limited to, the following: "POLICY A Plan of Care is part of the documentation process.... ...PROCEDURE... ...2. Complete the Plan of Care by including the following:... ...c. Identified need d. Realistic, measurable resident goal		with all new orders daily times two weeks, then three times a week for four weeks and then weekly for two months and then monthly. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA tio detiermine furtiher educational needs. Completion Date 9-26-2011	

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	e. Projected date the goal will be met f. Specific individualized interventions in the "Intervention" column... ...h. Signature and date..." 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, observation, and interview, the facility failed to ensure the nursing staff correctly transcribed and/or clarified physician's orders to ensure the correct medication was being given for 2 of 20 residents reviewed for correct medication administration in a Stage 2 Sample of 35. (Resident #'s 1 and 103) Findings include: 1.) During observation on 8/22/11 at	F0282	Residents #1 and 103 physician orders were reviewed immediately to ensure no clarifications were needed and any corrections were made. All physicians' orders were reviewed to ensure that no other orders for any resident needed to be clarified. All Nurses will be in-serviced to include the clarification of physician orders and transcription of physician order accuracy. This will be monitored by the DON or designee at DCR. Recommendations will be brought to the QA committee for review at	09/26/2011

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	10:00 a.m., LPN #4 administered an eye drop medication to Resident #1. The eye drop administered was Prednisolone AC 1% eye drops one drop to the left eye. The clinical record for Resident #1 was reviewed on 8/24/11 at 10:30 a.m. The clinical record for Resident #1 lacked any order for the Prednisolone 1% eye drop medication. The eye drop order was for Prednisolone AC 0.125% 1 drop to the left eye four times daily. The original date of this order was 7/6/11. During an interview with the LPN #4 and Unit Manager #5 on 8/24/11 at 10:40 a.m., additional information was requested related to the lack of an order for the Prednisolone AC 1% eye drop medication given to Resident #1. During an interview on 8/24/11 at 1:50 p.m., Unit Manager #5 indicated she had talked to the pharmacy regarding the eye drop order. She indicated the pharmacy told her they had sent out an "Urgent-need to clarify" notice related to the 7/6/11 eye drop order shortly after it was received indicating there was no 0.125 solution of Prednisolone eye drops and the order was written in error. Unit Manager #5 indicated she had no knowledge of		least monthly to ensure clarifications are completed and transcription of orders are accurate. Unit managers will review all new physician orders for needed clarification and appropriate transcription to MAR/TAR daily times two weeks, three times a week for four weeks, then one time a week for two months and monthly thereafter. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and	

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	the "Urgent-need to clarify" request having been received and the order had not been clarified and changed at that time. She indicated the physician had now been contacted and the order corrected to Prednisolone AC 1%. This indicated a time period of over 50 days that the nursing staff had administered the Prednisolone 1% eye drop medication to Resident #1 when both the medication administration record and the physician's order indicated Prednisolone AC 0.125 % was to be given. 2.) Resident #103's clinical record was reviewed on 8/24/11 at 1:15 p.m. The resident was admitted to the facility on 8/14/11. The resident's diagnoses included, but were not limited to, hypertension and a hepatic mass. The resident had hydrochlorothiazide [a diuretic-anti-hypertensive] on his admission orders. The order was written in two different areas on the order sheet and each order was different. One order indicated hydrochlorothiazide 25 mg, give one tablet orally everyday and the second order indicated the resident was to receive one 50 mg tablet orally		presentied tio QAA tio detiermine furtiher educational needs Completion Date 9-26-2011	

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	everyday. The resident's current orders were signed by the physician on 8/11/11 and contained the order written both ways. Review of the Medication Administration Record for August, 2011, indicated the resident received hydrochlorothiazide one tablet of 25 mg daily at 10:00 a.m., and 50 mg daily at 3:00 p.m. During an interview with RN #5, the Unit Manager for Resident #103, on 8/24/11 at 1:35 p.m., she indicated the hydrochlorothiazide order should have been clarified when the resident was admitted to the facility. She indicated she would contact the physician to have the order clarified. A clarification order for the hydrochlorothiazide was obtained on 8/25/11. The order indicated the hydrochlorothiazide 50 mg only should be given daily and a Basic Metabolic Profile blood test should be completed in one week. 3.1-35(g)(2)			

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F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure 1 of 1 resident reviewed with a Foley (urinary) catheter in a Stage 2 Sample of 35 had physician's orders for the size of the catheter and the bulb size of the urinary Foley catheter to be used. [Resident #21] Findings include: Resident #21's clinical record was reviewed on 8/24/11 at 2:00 p.m. The resident had signed, but undated, physician orders for August, 2011. The physician orders indicated the resident's urinary Foley catheter was for a neurogenic bladder and was to be changed monthly. There were no physician's orders for the size of the Foley catheter and the size the balloon was to be inflated.	F0315	Resident #21 physician's orders were clarified and an order for the foley catheter was obtained immediately. The orders did include size and type of catheter. Any resident who has a catheter was assessed to determine the need for any clarification of orders for size and type of catheter. No other residents were found to have a need for clarification of catheter orders. Nurses were in-serviced to ensure the proper transcription and order for catheters will be completed for any new or current residents who have catheters. This will be monitored by the DON or designee. Any recommendations will be reviewed by the QA committee at least monthly for any orders of residents with catheters to ensure the size and type is written in the order. DON/or designee will review all new physician Orders to ensure physician order for size	09/26/2011

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	Review of the Nurse's Notes indicated the following: 5/22/11, 10:00 a.m., Catheter changed with return of 400 cc's of amber urine. 5/23/11, 5:00 p.m., Resident returned for doctor's appointment at this time with no new orders. 5/24/11, 5:45 a.m., Resident's Foley catheter drainage bag emptied of 175 cc's of dark red urine. The medical doctor was notified on 5/23/11, when the catheter was changed and the resident had complained of pain. The resident had no complaint of pain at this time. 5/26/11, 1:00 a.m., The resident continues on an antibiotic for a UTI [urinary tract infection.] 5/27/11, 5:00 a.m., Antibiotic continues for UTI. 5/27/11, 3:15 p.m., The resident's catheter changed #14 French. Amber urine returned. The resident tolerated it well. 5/27/11, 11:30 p.m., Antibiotic continues for UTI without adverse effects. Urine light amber, acrid odor with white sediment. 5/28/11, 10:30 p.m., The resident continued on an antibiotic for UTI. 5/29/11, 6:00 a.m., Late entry for 5/28/11, 6:00 a.m. to 2:00 p.m., continues on an antibiotic for UTI and his urine remained foul.		of catheter And bulb size of foley catheter to be used during daily clinical review. Unit Managers will complete audits to ensure Residents with catherters have physician orders for Size of catherter and bulb size of foley catherter to be Used while reviewing trancscriptions to MAR/TAR daily times two weeks, then three times a week for four weeks and then weekly for two months and then monthly. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA tio detiermine furtiher educational needs. Completion Date 9-26-2011	

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	5/29/11, 5:25 p.m., New order from medical doctor for Macrodantin [an antibiotic] 100 mg two times a day for seven days for UTI. 5/29/11, 9:30 p.m., The resident continues on an antibiotic for UTI and his urine has a foul smell. His temperature is 100.0 degrees. 5/31/11 through 6/2/11, The urine was dark amber with a foul odor and the antibiotic continued for a UTI. 6/3/11 through 6/4/11, The resident continued on an antibiotic for a UTI. 6/18/11, 5:00 p.m., The resident stated his catheter fell out. A new 22 French with a 30 cc balloon catheter was put in. 7/2/11, 8:00 a.m., Catheter changed. A #18 French inserted with 300 cc amber yellow urine returned. 7/8/11, 12:00 p.m., Anchored catheter changed this morning due to leaking. Anchored catheter just changed on 6/25/11. Anchored catheter leaks frequently. Medical doctor notified and it is ok to send the resident to see a urologist. 7/13/11, 6:00 p.m., The resident returned from the urologist with no new orders. 7/19/11, 2:00 p.m., The resident's catheter came out. A #16 French Foley catheter with a 10 cc balloon was inserted. 7/31/11, 12:20 p.m., A #20 Foley			

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	catheter with a leg bag was inserted with a return of yellow urine. A "Physician Notification" form, dated 5/23/11, indicated the resident complained of pain from his catheter and the catheter was just changed. It indicated the resident had been on Bactrim DS [an antibiotic] two times a day from 5/5/11 to 5/11/11. The resident thought he had another UTI. A "Physician Notification" form, dated 5/24/11, indicated the resident complained of pain with urination and had blood in his catheter. The nurse indicated she was not sure if the blood was from trauma caused by the catheter or if the resident needed a urine analysis. A "Physician Notification" form, dated 5/30/11, indicated the resident had a large amount of yellowish, thick drainage from the penis and catheter. The resident was receiving Macrodantin 100 mg, two times a day for seven days and had a temperature of 100.9 degrees. During an interview on 8/22/11 at 2:47 p.m., with the RN #5, the Unit Manager for Resident #21, she indicated she did not know why the resident needed a catheter. She			

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	indicated the resident was admitted with a catheter on 3/25/11. During an interview with the Director of Nursing on 8/25/11 at 3:20 p.m., she indicated the resident did not have an order for the size of catheter the resident was to have. 3.1-41(a)(2)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure it was free from accident and/or fire hazards for 6 residents who occupied 3 of 34 rooms observed during the Stage 1 resident review process. (Room #'s 310, 231, and 232) Findings include: 1.) During an observation of Room # 310 on 8/23/11 at 9:30 a.m., the metal cover on the floorboard heater underneath the windows had a half section which had slipped down and was not covering the heating elements. This exposed a section of	F0323	Rooms 310, 231 and 232 rooms were immediately repaired for the electric baseboard heaters front covers. They were placed on the heaters properly and secured. All other rooms were audited and any other resident rooms and common areas that needed repair to the baseboard heaters were slated for repair. The Maintenance Director then went to each room identified from the audit and completed the repair to each baseboard heater and secured the front covers. Staff were provided in-serviced on 9-8-2011 to ensure the report of any unsafe condition to include missing baseboard heater covers and to fill out a work order and report the het cover for immediate	09/26/2011

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	rough, sharp, metal heating coils approximately 3 feet long. This room was occupied by two residents.		repair. Housekeeping will monitor for unsafe conditions daily on their daily cleaning schedule and report needs order forms and turning them in to maintenance. Weekly rounds will be made by the Administrator and maintenance man to ensure good repair of baseboard heaters. Any unsafe condition found will be reported to the Maintenance Director for immediate repair. This will be monitored by the administrator or designee. Any recommendations will be reviewed by the QA committee for work orders needed ensure a safe environment for residents areas. Maintenance supervisor will complete rounds daily times two weeks, then three times a week for four weeks and then weekly thereafter to ensure metal covers are properly placed over heaters. Adminitrator will complete room checks weekly for threes months. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further	

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			monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA to determine further educational needs. Completion Date 9-26-2011.	
	2. During an observation of Room 231 on 8/23/11 at 9:28 a.m., the electric wall board heater under the window was missing the cover over the heating coils. This room was occupied by two residents. 3. During an observation of room 232 on 8/23/11 at 9:32 a.m., the electric wall board heater under the window was missing the cover over the heating coils. This room was occupied by two residents. 4. During an interview with CNA #6 on 8/23/11 at 9:34 a.m., she indicated the electric wall board heaters work and the settings can be adjusted from low to high by the thermostats located in each resident's room. 5.) During an interview with the Administrator on 8/23/11 at 10:20			

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	a.m., concerns were addressed related to the exposed heating elements in Rooms 310, 231, and 232 noted above. The Administrator indicated he would have the maintenance staff address the concern right away. 3.1-45(a)(1)			
F0329 SS=E	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure 3 of 10 residents reviewed for unnecessary medications had a diagnosis to support the use of the medication [Resident #'s 21, 44, and 88] and	F0329	Residents #21, 44, and 88 blood pressure was assessed and a review of their medications was completed. Resident #27 was reviewed for unnecessary medications. A review of all residents'	09/26/2011

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	failed to monitor the blood pressure for 1 of 10 residents [Resident #27] reviewed for unnecessary medications in a Stage 2 Sample of 35. Findings include: 1. Resident #21's clinical record was reviewed on 8/24/11 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, and hypertension. The resident had signed, but undated physician orders for August, 2011. The physician orders indicated the resident was receiving finasteride [for benign prostatic hypertrophy] give one 5 mg tablet daily. The original date of the order was 3/25/11. Review of the medical record lacked a supporting diagnosis for the use of the medication. On 8/26/11 at 2:35 p.m., The Director of Nursing provided a 7/13/11, form with the diagnosis of History of BPH [benign prostatic hypertrophy.] She indicated the form was not in the resident's chart. She indicated she had just called the physician and had the form faxed to the facility.		medications was completed to determine if any resident had any unnecessary medications. All residents were reviewed for blood pressure monitoring and documentation in their clinical record. Nurses were in-serviced on the need to properly document Blood Glucose and Blood Pressure monitoring in the clinical record and recording in the correct location. Nurses were also in-serviced on the use of unnecessary drugs. This will be reviewed by the DON or designee. Any recommendations will be reviewed by the QA committee at least monthly to ensure the monitoring systems for documentation of blood glucose monitoring and blood pressure monitoring are in place and changed as needed. DON/or designee will review all new physician Orders to ensure appropriate diagnosis to support Use of medications during daily clinical review. Unit Managers will complete audits to ensure All medications have appropriate supporting Diagnosis daily times two weeks, then three times a week for four weeks and	

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	2.) The clinical record for Resident #88 was reviewed on 8/24/11 at 2:30 p.m. Resident #88's current diagnoses listed on the clinical record were, Parkinson's, tremors, alcohol abuse, seizure disorder, hypertension, anxiety and depression. Resident #88 had a current physician's order for Oxycodone (a narcotic pain medication) 7.5/325 milligrams 2 tablets every 4 hours to be administered routinely at 10 a.m., 2 p.m., 6 p.m., and 10 p.m. The		then weekly for two months and then monthly. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA tio detiermine furtiher educational needs. Completion Date 9-26-2011	

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	clinical record lacked any diagnosis related to why the resident was receiving the narcotic pain medication. During an interview with the Director of Nursing on 8/25/11 at 3:30 p.m., additional information was requested related to a diagnosis for the use of the routine narcotic pain medication. During an interview with the Director of Nursing on 8/26/11 at 3:00 p.m., she indicated the facility did not have a diagnosis on the clinical record to support the use of the routine pain medication for Resident #88. She further indicated the facility would call the physician and verify the indication for use of the medication. 3.) The clinical record for Resident #44 was reviewed on 8/24/11 at 9:45 a.m. Current diagnoses for Resident #44 included, but were not limited to, major depression, dementia, and right hemiplegia secondary to brain injury. Resident #44 had a current physician's order for the Docusate Sodium (a stool softener) 100 milligrams routinely at 8 a.m. and 8			

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	p.m. The clinical record lacked any diagnosis related to why the resident was receiving the stool softener medication on a routine basis. During an interview with the Director of Nursing on 8/25/11 at 3:00 p.m., additional information was requested related to a diagnosis to support the use of the medication. During an interview with the Director of Nursing on 8/26/11 at 3:00 p.m., she indicated the facility did not have a diagnosis on the clinical record related to the use of the routine stool softener medication. She further indicated the facility would call the physician and verify the indication for use of the medication. 4.) The clinical record for Resident #27 was reviewed on 8/24/11 at 1:31 p.m. Diagnoses for Resident #27 included, but were not limited to, hypertension, dementia with depression, asthma, gout, osteoarthritis, hypothyroidism, and diabetes mellitus. A signed recapitulation of physician's orders, dated 8/18/11, indicated			

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	Resident #27 had an order for a weekly blood pressure check. The original date of this order was 7/15/10. Resident #27 had a current physician's order for Norvasc (a blood pressure medication) 5 milligrams 1 tablet everyday. Resident #27 had a current physician's order for Lisinopril-hydrochlorothiazide (a blood pressure medication) 20-25 milligrams 1 table everyday. The Medication Administration Records for June and July were reviewed and out of 9 opportunities, four blood pressure readings were not documented. During an interview with the Director of Nursing (DoN) on 8/25/11 at 3:45 p.m., additional information was requested related to the lack of blood pressure monitoring on 6/8/11, 6/15/11, 7/21/11 and 7/18/11. During an interview on 8/26/11 at 11:48 a.m., the RN Consultant indicated she did not have any additional information to provide related to the lack of blood pressure monitoring on 6/8/11, 6/15/11, 7/21/11 and 7/18/11. 3.1-48(a)(3) 3.1-48(a)(4)			

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F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 2 of 10 residents observed receiving medications. 3 errors in medication were observed during 50 opportunities for error in medication administration. This resulted in a medication error rate of 6%. [Resident #'s 15 and 13] Findings include: 1. LPN #2 was observed passing medications to Resident #15 on 8/24/11 at 10:40 a.m. The LPN failed to give the resident Thera-Plus [multivitamin] liquid 5 ml's and Potassium Chloride [a mineral supplement] 25 mEq [milli-equivalent] tablet. LPN #2 indicated at the time the medications were not available. Resident #15's clinical record was reviewed on 8/24/11 at 10:45 a.m. The resident's 8/18/11, signed physician orders included, but were not limited to, Thera-Plus liquid give 5	F0332	Residents #15 and 13 were assessed for any potential adverse reactions from the medication error. The physician and family were notified. The nurse was immediately disciplined for the medication error. LPN #2, RN #3 were counseled. Monitoring of medication pass is provided by the UM daily to ensure the residents are receiving the proper medication. In-service training has been provided to the nurses on proper pass medication procedure. This will be monitored by the DON or designee. Any recommendations will be brought to the QA committee to ensure med pass procedures are in place. Education Training Director will complete medication administration observations with all licensed nurses with any needed follow up education. DON/or designee will complete medication administration observations once a shift	09/26/2011

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	ml via g-tube [gastronomy tube] once a day, and potassium chloride 25 mEq tablet give one tablet dissolved via g-tube once a day. 2. RN #3 was observed passing medications to Resident #13 on 8/24/11 at 3:43 p.m. The RN gave Resident #13 a calcium 500 mg with 200 IU [international units] of vitamin D [a vitamin and mineral supplement] tablet orally. Resident #13's clinical record was reviewed on 8/24/11 at 3:45 p.m. The resident's current physician's orders were signed on 7/21/11. The orders included, but were not limited to, calcium 500 mg with vitamin D 200 IU give one tablet orally three times a day with meals. The resident was not given any food with the medication and the evening meal was scheduled to be served between 5:00 p.m. and 5:30 p.m. The current 2008, revised Procedure for Medication Administration was provided by the RN Consultant on 8/26/11 at 1:30 p.m. The procedure indicated the licensed nurse and/or medication assistant will check for the right time when passing medication. These findings resulted in a		weekly for two months and then weekly for one month and then as needed for any identified trends. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA tio detiermine furtiher educational needs. Completion Date 9-26-2011	

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	155038	A. BUILDING 00 B. WING	08/26/2011

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	medication error rate of 6 percent. 3.1-48(c)(1)			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure medication orders were clarified related to two different orders for a diuretic blood pressure medication resulting in the resident getting two doses daily instead of one. This affected 1 of 10 residents reviewed for significant medication errors in a Stage 2 sample of 35. Resident # 103 Findings Include: Resident #103's clinical record was	F0333	Resident #103 was assessed for any potential adverse reactions from the medication error. The physician and family were notified. The nurse was immediately disciplined for the medication error. Monitoring of medication pass is provided by the Unit Manager daily to ensure the residents are receiving the proper medication. In-service training has been provided to the nurses to teach them the proper way to pass medication and to eliminate errors in passing medication. This will be monitored by the DON or designee. Any	09/26/2011

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	reviewed on 8/24/11 at 1:15 p.m. The resident was admitted to the facility on 8/4/11. The resident's diagnoses included, but were not limited to, hypertension and a hepatic mass. The resident had two different physician's orders for hydrochlorothiazide [a diuretic-antihypertensive] on his admission orders. One order indicated hydrochlorothiazide 25 mg, give one tablet orally everyday and the second order indicated the resident was to receive one 50 mg tablet orally everyday. The resident's current orders were signed by the physician on 8/11/11. Review of the Medication Administration Record for August, 2011, indicated the resident received hydrochlorothiazide one tablet of 25 mg daily at 10:00 a.m., and 50 mg daily at 3:00 p.m. from August 5, 2011 through August 23, 2011. During an interview with RN #5, the Unit Manager for Resident #103, on 8/24/11 at 1:35 p.m. She indicated the hydrochlorothiazide order should have been clarified when the resident was admitted to the facility. She indicated she would contact the physician to have the order clarified.		recommendations will be brought to the QA committee to ensure med pass procedures are in place DON/or designee will review all new physician Orders are transcribed properly to MAR/TAR during daily clinical review. Unit Managers will complete audits to ensure All physician orders have been transcribed appropriately To MAR/TAR daily times two weeks, then three times a week for four weeks and then weekly for two months and then monthly. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA tio detiermine furtiher educational needs. Date 9-26-2011	

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	A clarification order for the hydrochlorothiazide was obtained on 8/25/11. The order indicated the hydrochlorothiazide 50 mg only should be given daily and a Basic Metabolic Profile blood test should be completed in one week. 3.1-48(c)(2)			
F0364 SS=E	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on record review and interview, the facility failed to ensure meals served to the residents were served at a hot, palatable temperature for 4 of 19 residents reviewed for food quality in a Stage 2 Sample of 35. (Resident #'s 76, 10, 40, and 48) Findings include:	F0364	Residents #76, 10, 40, and 48 had voiced a concern at the Resident Council about cold food. They will be interviewed to determine their choice of the food temperatures and also the passing of ice water and to determine their need for improvement on the food temperatures and passing ice water. Staff were in-serviced on	09/26/2011

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	1. Review of the resident council minutes from January 2011 through August 2011, the following food related concerns were noted: January 7, 2011: "Food usually cold." February 3, 2011: "Breakfast on hall still cold." April 19, 2011: "Meals not always hot." June 20, 2011: "Food is okay, but always cold." During an interview with Resident #40, the Resident Council President, (identified as "interviewable" by the facility) on 8/25/11 at 1:00 p.m., he indicated residents have told him the food is sometimes cold. He indicated council grievances are not always fully acted upon. Sometimes the problems still occur and there continues to be concerns related to cold food. 2. The clinical record for Resident #10 was reviewed on 8/24/11 at 2:30 p.m. A quarterly Minimum Data Set assessment, dated 6/10/11, indicated Resident #10 had no problems with his ability to understand others. During an interview with Resident #10 on 8/23/11 at 9:20 a.m., information		9/8/2011 to ensure the provision of proper food temperatures and ice water is passed every shift and as per resident requests. Foods will be monitored and temperatures taken daily on all meals. Residents will be interviewed daily for compliance of food temperatures and ice water being passed each shift and the Resident Council will be asked at its regular monthly meetings if food temperatures and ice water pass is being provided each shift and as requested or desired. Any concerns that the Resident Council addresses will be written on a Resident Concern Form and provided to the Administrator. Remedy, action or resolution will be addressed and the next regularly scheduled Resident Council meeting. This will be monitored by the administrator or designee. Any recommendations will be reviewed by the QA Committee to ensure any concerns are addressed from the Resident Council to include Food Temperatures and the procedure of passing ice water at its regularly scheduled monthly or as needed for compliance. Dietary manager will monitor temperature and Palatable of hall and dining room trays daily times two weeks, then three times a week	

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	was requested regarding facility meals and food service. Resident #10 indicated he ate his meals in his room. He indicated there were still problems with cold food and the food was not always hot. 3. The clinical record for Resident #76 was reviewed on 8/24/11 at 10 a.m. Resident #76 was identified as interviewable on the facility "Interviewable" list. During an interview on 8/23/11 at 12:55 p.m., Resident #76 indicated there continued to be problems with the food being cold. She indicated she eats her meals in her room. She indicated the food was cold at times, "almost every day." 4. During an interview on, 8/23/11 at 12:50 p.m., Resident #48 (identified as interviewable on the Interviewable list), indicated he ate meals in his room. He indicated the food was often cold by the time he got it. He indicated he had talked to the Dietary Manager about the cold food. 3.1-21(a)(2)		for four weeks and then weekly. Administrator will follow up with dietary temperature logs weekly to ensure proper temperatures are being observed. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA to determine further educational needs. Completion Date of 9-26-2011.	

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F0428 SS=D	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the Consultant Pharmacist failed to identify 3 of 10 residents reviewed for unnecessary medications in a Stage 2 sample of 35 for the use of medications without a supporting diagnosis. [Resident #'s 21, 44, and 88] Findings include: 1). Resident #21's clinical record was reviewed on 8/24/11 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, and hypertension. The resident had signed, but undated physician orders for August, 2011. The physician orders indicated the resident was receiving finasteride [for benign prostatic hypertrophy] give one 5 mg tablet daily. The original date of the order was 3/25/11. Review of the medical record lacked a supporting diagnosis for the use of the medication.	F0428	Residents #21, 44 and 88 were reviewed for unnecessary medications without a supporting diagnosis. Diagnosis were located in the clinical record and identified on the chart, pharmacy was notified to include on the rewrites each month. All residents' charts were reviewed to identify any resident who had a diagnosis that was not listed in the clinical record and corrections were made immediately. Clinical review will occur daily at DCR for changes needed in the clinical record.Monthly reviews of the resident's clinical records will be completed by the DON. This will be monitored by the DON or designee. Any recommendations will be reviewed by the QA committee to ensure any changes needed to the clinical record followed. Consultant Pharmacist will review resident medications Monthly for any unnecessary medications and make Recommendations as necessary.	09/26/2011

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	The August, 2011, physician's orders indicated the resident's medications were reviewed by the Consultant Pharmacist on 8/4/11. There was no pharmacy recommendation on the clinical record indicating finasteride did not have a supporting diagnosis. On 8/26/11 at 2:35 p.m., The Director of Nursing provided a 7/13/11, form with the diagnosis of History of BPH [benign prostatic hypertrophy.] She indicated the form was not in the resident's chart. She indicated she had just called the physician and had the form faxed to the facility. 2.) The clinical record for Resident #88 was reviewed on 8/24/11 at 2:30 p.m. Resident #88's current diagnoses listed on the clinical record were, Parkinson's, tremors, alcohol abuse, seizure disorder, hypertension, anxiety and depression. Resident #88 had a current physician's order for Oxycodone (a		DON/or designee will review all new consultant pharmacist Recommendations with physician and obtain orders as needed. Identified trends will be reviewed in QAA monthly x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA tio detiermine furtiher educational needs. Completion date 9-26-2011	

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	narcotic pain medication) 7.5/325 milligrams, 2 tablets, every 4 hours to be administered routinely at 10 a.m., 2 p.m., 6 p.m., and 10 p.m. The original date of the order was 6/4/11. The clinical record lacked any diagnosis related to why the resident was receiving the narcotic pain medication. The clinical record indicated the facility's Pharmacy Consultant had reviewed Resident #88's record on 7/9/11. The Pharmacy Consultant's report lacked any documented diagnosis to support the use of the routine narcotic pain medication. During an interview with the Director of Nursing on 8/25/11 at 3:30 p.m. additional information was requested related to a diagnosis for the use of the routine narcotic pain medication. During an interview with the Director of Nursing on 8/26/11 at 3:00 p.m. she indicated the facility did not have a diagnosis on the clinical record to support the use of the routine pain medication for Resident #88. She further indicated the facility would call the physician and verify the indication for use of the medication.			

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	3.) The clinical record for Resident #44 was reviewed on 8/24/11 at 9:45 a.m. Current diagnoses for Resident #44 included, but were not limited to, major depression, dementia, and right hemiplegia secondary to brain injury. Resident #44 had a current physician's order for the Docusate Sodium (a stool softener) 100 milligrams routinely at 8 a.m. and 8 p.m. The clinical record lacked any diagnosis related to why the resident was receiving the stool softener medication on a routine basis. The clinical record indicated the facility's Pharmacy consultant had reviewed Resident #44's clinical record on 6/6/11, and 7/9/11. The Pharmacy Consultant's reports lacked any indication of a diagnosis to support the use of the routine stool softener medication. During an interview with the Director of Nursing on 8/25/11 at 3:00 p.m., additional information was requested related to a diagnosis to support the use of the medication.			

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	During an interview with the Director of Nursing on 8/26/11 at 3:00 p.m., she indicated the facility did not have a diagnosis on the clinical record related to the use of the routine stool softener medication. She further indicated the facility would call the physician and verify the indication for use of the medication. 3.1-25(h)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure blood sugar results, sliding scale insulin and routine insulin was documented in the clinical record for 1 of 4 residents reviewed with physician's orders for blood sugar monitoring and insulin (resident #48). The facility also failed to ensure resident treatments were accurately documented for 1 of 8 residents reviewed for treatments (Resident #6) in a Stage 2 Sample of	F0514	Resident #48 blood glucose was assessed immediately and determined to have no negative impact. Resident #6 was assessed for treatments and no changes were required. All resident clinical records were reviewed to determine if the documentation needs were met to ensure the need for assessment or changes in condition as it relates to documentation in the clinical records for treatments or blood glucaose monitoring.	09/26/2011

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	34. Findings include: 1.) The clinical record for Resident #6 was reviewed on 8/25/11 at 8:45 a.m.. Resident #6's current diagnoses included, but were not limited to hypertension, peripheral vascular disease, seizure disorder, iron deficiency, Parkinson's bronchitis and neuropathy. During an interview with Resident #6 on 8/23/11 at 8:56 a.m., she indicated her arms hurt her all the time. The Resident indicated the nurses "rub cream on them and it really helps." The resident indicated she had been without the cream for "18 days." She indicated the cream was in a yellow tube. A Quarterly Minimum Data Set Assessment, dated 6/10/11, indicated the resident was independent with cognitive ability and could make her own decisions. Resident #6 was on a list of residents who were interviewable that was provided by the Administrator on 8/22/11 at 12:00 noon. Resident #6 had a healthcare plan,		All treatment records and Blood Glucose Monitoring was audited and inservice training was provided to the nurses on documentation requirements for these two issues. Audits will be completed daily to determine any deficient practice in the documentation for monitoring of blood glucose or treatments. This will be monitored by the Don or designee. Recommendations will be made to the QA committee to ensure blood glucose monitoring system is in place. Unit Managers will complete MAR/TAT audits to ensure Blood sugar results, sliding scale insulin and routine insulin Is documented daily times two weeks, then three times a week for four weeks and then weekly for two months and then monthly. DON/or designee will review MAR/TAR weekly for three months to ensure blood sugar results, sliding scale insulin and rountin insulin is documented. Identified trends will be reviewed in QAA monthly	

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	dated 6/6/11, which indicated the resident had a problem listed as alteration in comfort related to pain secondary to generalized discomfort. Interventions for this problem included, administer pain medication as ordered, monitor and record effectiveness of medication, assess for verbal and non-verbal signs and symptoms of distress or pain unrelieved by ordered treatments/medications. Resident #6 had a current physician's order for Aspercream 10% cream, apply topically 3 times a day as needed. The original date of the order was 6/30/11. During observation and interview with Nursing Staff #1 on 8/25/11 at 9:17 a.m., she indicated Resident #6 did have an order for Aspercream, three times daily. The Aspercream treatment was in a yellow tube. She indicated the cream should be applied by nursing and documented when it was applied. Nursing Staff #1 went to the treatment cart and Resident #6 had an empty tube of Aspercream topical treatment in the cart. The Aspercream was labeled as having been received from the pharmacy on 7/31/11. The nurse indicated she was not aware the medication was empty		x 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be presented and reviewed during QAA tio detiermine furtiher educational needs. Completion Date 9-26-2011	

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	and she would re-order. The July and August 2011 treatment sheet for Resident #6 lacked documentation of any Aspercream having been applied at any time for the months of July and August. The treatment sheet had the listed as Aspercream 10 % cream apply topically 3 times a day as needed. The treatment sheets were blank. No nursing initials were present on the treatment sheets to indicate the treatment had administered by nursing staff, even though the tube of Aspercream was empty. 2.) The clinical record for Resident #48 was reviewed on 8/24/11 at 9:45 a.m. Resident #48's current diagnoses included, but were not limited to, diabetes mellitus, hypertension, depression, and congestive heart failure. Resident #48 had physician's orders for the following, A. Monitor blood glucose levels before meals and at bedtime. 7:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m. The original date of this order was 12/9/10			

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	B. Administer Novolog sliding scale insulin coverage based on blood glucose results according to the scale below, 200 - 250 = 2 units 251 - 300 = 4 units 301 - 350 = 6 units 351 - 400 = 8 units less than 70 or greater than 400 call the physician. C. Administer Novolog 15 units before lunch. Review of the June Medication Administration Record (MAR) for Resident #48 lacked documentation of any blood glucose results on June 12, at 4 p.m., and June 24, at 4 p.m. Review of the June MAR for Resident #48 lacked documentation of Novolog 15 units being given before lunch on June 10, 14, 24, 27, and 30. During an interview with the Director of Nursing on 8/25/11 at 3:45 p.m., additional information was requested related to the lack of blood sugar results and Novolog 15 units before lunch documentation on the dates and times noted above. During an interview on 8/26/11 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	11:48 a.m., the RN Consultant indicated she did not have any additional information to provide related to the lack documentation for blood sugar results, or the 15 units of Novolog administration before lunch for the dates and times noted above. 3.1-50(a)(1) 3.1-50(a)(2)			